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## If They Can Consent, Why Can't They Refuse?

Tom Walker

### Introduction

Medical ethics and medical law both hold that where the patient is a competent adult (in Ireland that is a competent person over 18) it would always be wrong to give her medical treatment that she has refused. In contrast whilst section 23 of the Non-Fatal Offences Against the Person Act 1997 stipulates that young people in Ireland who are 16 or over can consent to medical treatment, it does not specifically include an entitlement to refuse treatment. As such, it would appear that in Ireland 16 and 17 year olds can consent to medical treatment but it is not clear that they can effectively refuse it (Law Reform Commission, 2011: .50-56; *HSE v JM and Another* [2013] IEHC 12; *XY and McEvoy v HSE* [2013] IEHC 490 ). This is not, of course, to deny that they can say they do not want treatment; it is to say that it is not clear that their refusal is sufficient to prevent them from being given the treatment. This situation is not unique to Ireland. Something similar is the case in relation to children's consent to, and refusal of, treatment in other jurisdictions, including that of Northern Ireland. In these jurisdictions whilst a child of whatever age can give consent provided she has sufficient understanding and intelligence to enable her to fully understand what is proposed, the courts have allowed this refusal of treatment to be overridden where this is judged to be in the best interests of the child (see Archard, 2007; Law Reform Commission, 2011:.56-89); Gilmore and Herring (2011); Cave and Wallbank (2012) for a discussion of these cases).

The idea that a person could consent to medical treatment but not effectively refuse it, however, seems problematic. This is because there appears to be a necessary connection between consenting and refusing. In consenting what the patient does is, in David Owens' phrase, to shape the normative landscape (Owens, 2012) – she brings it about that it would not be wrong to do something that it would otherwise be wrong to do in the absence of that consent. As a result if 16 and 17 year olds (who I will refer to as young people) can consent to medical treatment

then it must be the case that it would be wrong to give them that treatment without their consent. Because of this close connection between consent and refusal the Law Reform Commission in its 2011 report on *Children and the Law: Medical Treatment* recommended that “legislation should clearly provide that, in general, a person who is 16 or 17 years of age is presumed to have the capacity to consent to, and refuse, health care treatment” (Law Reform Commission, 2011: p.92), and that as a result in general terms “a 16 and 17 year old would not be subject to any countervailing test, such as whether the specific treatment is in their “best interests”” (Law Reform Commission, 2011: 93). The Report recommends an exception to this in some cases where the treatment refused would be life sustaining (Law Reform Commission, 2011: 94-95).

In this chapter I want to argue against this proposal and argue that it is not required by the close connection between consent and refusal. There are in fact two ways in which we might set out this connection, each of which locates the source of the problem in a different place. The first focuses on the claim that it would be morally wrong to give a patient medical treatment without their *voluntary* consent, and argues that for it to be possible to voluntarily consent to something we must believe that it will not happen if we do not agree to it being done. The second focuses on the reasons it would be morally wrong to give a patient medical treatment she has refused, and the role played by consent in ensuring that giving such treatment would not be morally wrong. I will consider these in turn. As we will see, at least for the majority of cases, there is a fairly straightforward response to the first way of setting out the problem. In contrast, whether the second way of setting out the link between consent and refusal creates a problem will turn out to depend on whether young people are autonomous. If, as I will argue, they are, then there is a relatively straightforward argument to support the idea that they can consent to, but not effectively refuse, medical treatment. What will turn out to require further explanation, at least on standard ways of approaching medical ethics, is the idea that it is always morally wrong to give an adult treatment that she refuses.

### ***The Meaning of Consent***

Before starting, however, I need to say a bit more about consent. In practice a patient consents to medical treatment by communicating to the relevant healthcare provider her agreement to being given that treatment. However, as is well known merely agreeing to something being done does not always shape the normative landscape in the required way. As Stephen Wilkinson has pointed out, if a person issues a 'your money or your life' threat and you agree to give them your money, whilst you have consented (that is, agreed) to them taking the money it is nevertheless still wrong for them to take it (Wilkinson, 2003:.75). For this reason for a patient's consent to change the normative situation from one in which it would be wrong for her doctor to give her treatment to one where doing this would not be wrong, her consent has to meet certain conditions. These are standardly taken to be that: she is competent, her consent is given voluntarily, and she is sufficiently informed about what is being proposed (Wilkinson, 2003:.76-78; Gillon, 1986:.113). Where a patient's agreement to have medical treatment meets these three conditions she is said to have given valid consent. It is for reasons such as this that most work in bioethics refers to valid consent rather than simply to consent.

If we take the word 'consent' as in the previous paragraph to refer to an agreement, then there will turn out to be no problem in holding that a person can consent to something but cannot effectively refuse it. As we have seen with Wilkinson's example there is no problem with being able to agree to something that you believe will happen anyway. To consent, however, also has a second meaning in English – to grant permission or to make permissible. When used in this way 'consent' refers to something that, as I put it above, shapes the normative landscape in a particular way. If a person consents to your doing something in this sense they make it the case that it is not wrong for you to do that thing (Raz, 1986:81; Feinberg, 1986:177; Manson, 2007:297-298). On this way of using the word, in contrast to what was said above, you have not consented to the robber taking your money (though you have agreed to him doing so). It is consent in this sense, something that makes permissible an act that would otherwise be wrong, that creates the problem I am concerned with in this chapter. As such, when I refer to a patient giving consent for medical treatment in what follows I mean to refer to the patient making it the

case that the doctor would not be acting wrongly were she to give that patient that treatment.

**Can you *voluntarily* agree if you cannot effectively refuse?**

The first way of setting up the link between consent and refusal rests on the idea that for a patient's agreement to make a difference to whether or not it is morally wrong to give her treatment, her agreement must (along with meeting certain other requirements) be given voluntarily. This is because a patient's voluntary agreement to have a certain treatment indicates that she has decided of her own free will to have that treatment rather than some other treatment or no treatment at all. In contrast, her saying she agrees to the treatment in a situation where she believes it will be given to her even if she refuses indicates no such thing. In this case the choice she faces is not between having this treatment and not having it (or having some other treatment), it is between going along with something that is going to happen anyway or resisting it. Her saying she agrees to have the treatment in this case does not mean she has voluntarily agreed to have the treatment but rather that she has acquiesced to being given it. And acquiescing to something we take to be inevitable does not constitute giving permission (and hence does not constitute giving consent) for it to be done. It is for this reason that Neil Manson and Onora O'Neill argue that for a person to be able to consent to medical treatment they must know that they have a real choice about whether or not to have it (Manson and O'Neill, 2007:93). If this is right then in order to be able to consent to medical treatment a person must believe that she has a real choice about whether or not to have it. But if it would be given to her even if she does not agree, then she does not have a real choice in this way. Hence, in that situation the fact that she cannot effectively refuse means that she cannot really consent.<sup>i</sup>

There is certainly something in this, but it may not be as big a problem as it at first appears. This is because the key point being made here is that a patient cannot effectively consent to treatment if she believes that she would be given it anyway. Whilst there may be cases of this type when it comes to young people (those cases where treatment would be given to them if they refuse) there are many other cases that are not like this. That is, even if it were permissible to give a young person

treatment she refuses, it does not follow that she will be given that treatment if she refuses it. It is in practice difficult to give medical treatment to a young person who does not want it, particularly where the treatment requires the young person's co-operation (as is the case where it requires them to take medication at regular intervals or to comply with restrictions on their lifestyle). In these cases for all practical purposes the young person has an effective veto over whether or not she receives the treatment, something she may well be aware of. In cases of this type it is not true that medical treatment will be given to the young person irrespective of what she wants.

Because as we have seen in many cases a young person's refusal of treatment will not in practice be overridden (something that she may well be aware of) in these cases it seems that there is nothing in what has been said so far to show that she cannot consent to those treatments. Things may be different in those limited number of cases where her refusal would be overridden were she to refuse. Even here, however, whether the patient can voluntarily agree to the treatment will depend on whether or not she believes it is up to her whether it is given or not. If she believes it is then there is nothing to say that her agreement could not be given voluntarily, even if it turns out that were she to refuse that refusal would be overridden.

As such, whilst it is true that a person cannot consent to something that she believes will happen anyway, and so needs to believe that if she refuses treatment this will not be overridden if she is to be able to consent to that treatment, this does not create the blanket problem for the idea that young people can consent that it appeared to. The points made here about the connection between consent and refusal show they are linked, but this link is very specifically tied to the details of the particular case. There is no problem, for all that has been said so far, in it being the case that young people can consent to some treatments (and in these cases if they refuse they will not be given the treatment) but cannot consent to others (those cases in which if they refuse they will be given the treatment anyway). That is, this way of setting up the objection does not show that there is a real problem with the combination of normative positions we started with (young people can consent to treatment but it is permissible to give them medical treatment even if they refuse).

The problem dissolves once we see that the things they can consent to and the things that they cannot refuse are not one and the same.

### **Consent and Respect for Autonomy**

The argument we have just been considering focuses on what the patient believes would happen if she refuses treatment. However, we could also set out the link between consent and refusal in a way that is not affected by the practicalities of giving patients treatment they do not want. Recall that consenting in the sense that is important here is a making permissible – in particular where a patient consents to medical treatment she makes it the case that something that would otherwise be morally wrong, giving her the treatment, would not be morally wrong. This creates a necessary link between consent and effective refusal. If it would not be wrong to give a patient treatment she refuses then she cannot make it permissible for you to give her that treatment (and hence cannot effectively consent to that treatment) because it is already permissible for you to do so. On the other hand, if she can consent it must be the case that it would be wrong to give her the treatment without her consent, and hence wrong to give her treatment she has refused.

In the case of competent adults it is standardly held that the reason it would be wrong to give them treatment without their consent is that to do so would fail to respect their autonomy, and doctors have an obligation to respect their patients' autonomy. A patient's consent changes the normative status of providing treatment because it brings it about that in providing that treatment her doctor is not acting in a way that fails to respect her autonomy – something the doctor would be doing were she to give her patient treatment she has refused. As such, if the young people who are our concern in this chapter are autonomous it would be the case, just as it is with adults, both that they can consent to medical treatment and that it would be wrong to give them treatment they refuse. On the other hand, if they are not autonomous then it would not be a failure to respect their autonomy to give them treatment they have refused – and so would not be wrong on those grounds. In addition in that case they would not be able to consent – that is, they would not be able by agreeing to treatment change the normative situation to bring it about that it is not wrong on the grounds of failing to respect their autonomy to give them the

treatment. The reason for this is that you cannot change the situation to bring it about that something would not be wrong if it is already the case that it is not wrong. In this section I will argue that there is at least one sense in which competent young people are autonomous and it is this that explains why they can consent to treatment. Then, in the final section, I will argue that despite this there will be cases where it is not wrong to give them treatment they have refused.

### ***Are young people autonomous?***

To be autonomous is to be self-governing. But what it means to be self-governing, and hence to be autonomous, can be conceptualized in a variety of different ways (Dworkin, 1988:3-6; Arpaly, 2003: 117-148). Not all of these are relevant to discussions in medical ethics but even within this field different writers use the term in different ways (Wilson, 2007; Walker, 2013). In this section I want to argue that there is a sense of autonomy that both supports the idea that giving a competent patient medical treatment she refuses is wrong on the grounds that it does not respect her autonomy, and according to which the young people that are our concern in this chapter are autonomous.<sup>ii</sup>

In order to be self-governing an individual needs to be able to do certain things. What they need to be able to do has been spelt out in different ways. Raanan Gillon for example takes autonomy to be, “the ability and tendency to think for oneself, to make decisions for oneself about the way one wishes to lead one’s life based on that thinking, and then to enact those decisions ...” (Gillon, 2003:310). Gerald Dworkin, on the other hand, takes it that autonomy is the capacity to think about what one wants or prefers, and either to identify with those preferences (where this simply means that if one were to reflect on whether one really wanted these things one would judge that one did, or would be content to be a person with these wants) or to change them (Dworkin, 1988:108). At its heart, then, this type of account says that autonomy is the capacity to think about what you want, to make decisions about what you want taking into account your aims and values, and then to act on those decisions.

That someone has a particular ability does not necessarily pose any obligations on others. For example, that I have in some sense the ability to learn



Russian does not mean that anyone else has any obligation to teach me Russian. But the capacity for autonomy is not like this. We not only have this capacity, it is also important to us that we exercise it. There are both instrumental and intrinsic reasons for this (Dworkin, 1988:112). When I exercise my capacity for autonomy to decide what to do, or what will be done to me, I make that decision taking into account my aims and the things that are important to me. Others, even where they care about me, will tend to make decisions about what is to be done to me on the basis of what they think is important. Because what I judge to be important and what others judge to be important may well vary, if I make the decision about what is to be done then it is more likely that this will achieve my aims. As such, it seems that my life will go better if I am the one to choose what happens to me (Mill, 1859; Dworkin, 1988:111-112; Owens, 2012:166-7).

But, being the one to make decisions for myself is not valuable to me just because it promotes my wellbeing. It is also valuable to me because, as Dworkin puts it, "The exercise of the capacity of autonomy is what makes my life *mine*" (Dworkin, 1988:111). Because of this it is important to us as individuals that we be recognised and treated as individuals who have this capacity. As David Owens has put it, "If I live in a society in which most people are allowed the choice of whether to wear a crash helmet whilst cycling, the fact that I (and people like me) are deprived of this choice will be demeaning. It carries the message that they are competent to decide this matter but I am not." (Owens, 2011:409) That is, given the value that we place on being treated as if we have the capacity for autonomy, to fail to treat someone as having that capacity would constitute a failure to respect them as a person, and doing so can be very hurtful to the person concerned (for a similar view in relation to respect for persons see Raz, 2001:169-175). The basic idea here is that failure to respect autonomy in this sense is morally problematic given the importance we attach to making our own decisions about how our life might go.

We can now see why giving an autonomous patient medical treatment that she has refused is morally wrong. To treat her in this way would be to fail to take adequate account of her interest in deciding for herself the way her life should go and also fail to take account of her interest in being allowed to make this decision for herself. If a doctor were to act in this way, she would be failing to recognise both the

importance to the patient of making this type of decision for herself, and the importance to the patient of being treated as someone who can make this type of decision. Instead of treating her patient as an agent capable of making up her own mind, the doctor would be treating her as someone incapable of doing so, or as someone who would do it so badly that she needs someone else to make decisions for her. This would be a failure to respect her patient's autonomy in the sense we are concerned with here. On the other hand if a patient has voluntarily agreed to have a particular treatment then in making that decision she exercises her capacity for autonomy. In then giving her the treatment her doctor respects her autonomy (in the relevant sense). The doctor does not in any way set back her patient's interest in being treated as a person who can make, and be trusted to make, her own decisions. And nor does she set back her patient's interest in making her life her own and controlling what happens to her.

Having set out this account of autonomy and its relation to consent we now need to consider whether young people are autonomous in this sense. It seems that they are. Anyone who meets the criteria by which an adult would be judged as being competent to make a certain decision will also be autonomous (Dworkin, 1988:111). This is because the criteria for being a competent person and those for being an autonomous person "are strikingly similar" (Beauchamp and Childress, 2009: 113) to the extent that as Tom Beauchamp and James Childress point out, "Law, medicine, and, to some extent, philosophy, presume a context in which the characteristics of a competent person are also the properties possessed by the autonomous person." (Beauchamp and Childress, 2009: 113). It is widely accepted that at least some young people meet these criteria. Furthermore, it would seem that 16 and 17 year olds have an interest in being recognised as able to make decisions for themselves, and take it that being treated as able to do so is important to them. The importance of shaping our own lives and making our own decisions, and of being treated as an equal in this respect, is not something that comes on over night. It develops over time and as it does so our interest in being treated like an adult develops with it. Given this, if all those who are 18 have this set of interests, it must be the case that at least some of those under 18 also have them.

What we can conclude from this is that young people who meet the standard for an adult to be competent are autonomous – that is they have the capacities needed to be judged as being autonomous – at least in this context. We can also conclude that it would be wrong to give a competent young person medical treatment she refuses because to do so would fail to respect her interests in making, and being treated as competent to make, her own decisions about what is to happen to her. In this the wrong that would be done to a competent young person by giving her treatment she refuses is just the same type of wrong that would be done by giving a competent adult medical treatment she refuses. Similarly, just as an adult's voluntarily given, informed, agreement to have treatment means that in giving her the treatment the doctor would be respecting her autonomy, the same would be the case for the voluntarily given, informed, agreement of a competent young person. Because of this the young person's consent is needed in order to respect her autonomy (just as for an adult), and it would be wrong to give her treatment without that consent – to do so would be to fail to respect her autonomy (and hence wrong on the same grounds that giving a competent adult treatment without his consent would be wrong). Furthermore, because the interest that is being protected by the requirement for consent is an interest in a young person making her own decisions there are no grounds for holding that a different standard should be used to determine the capacity to refuse from that used to determine the capacity to consent. To do so would be to hold that whether or not a young person is autonomous, that is whether or not she has the capacity to decide which course of action to take, depends on what she actually decides.

***Is it always wrong to give a young person treatment she has refused?***

If what has been said so far is correct then young people who pass the (adult) threshold for competence can consent to medical treatment in exactly the same way and for exactly the same reasons as adults. It might appear that this means that it would always be morally wrong to give such a young person medical treatment that she refuses. In this section I want to look at a possible response to this point – one that would allow us to hold that, despite all that has been said so far, it is not always wrong to give a competent young person medical treatment she refuses. As we will

see on a widely held position in medical ethics this turns out to be what we should expect.

The position we have arrived at is that it would always be wrong, because it would be a failure to respect her autonomy, to give a competent young person medical treatment that she refuses. However, doctors do not only have an obligation to respect autonomy. Standardly they are also thought to have obligations to act on the duties of beneficence, non-maleficence and justice (Beauchamp and Childress, 2009; Gillon, 1986). In practice these different obligations sometimes require conflicting things of us. A standard example to illustrate this would be a case in which a competent adult refuses treatment (and so ought not to be given treatment because to do so would fail to respect her autonomy) that is best for her (and so giving her the treatment is required in order to fulfil the duty of beneficence). In such situations one way of determining what we should do is to weigh the conflicting obligations against one another to see which is most important in the given circumstances (Beauchamp and Childress, 2009:19-24). What this means is that something could be *prima facie* wrong on the grounds that it fails to respect a person's autonomy, but not wrong all things considered. This would be the case where some other obligation, such as the obligation to do what is best for the patient, outweighs the obligation to respect her autonomy. The problem it might be thought with the argument so far is that it fails to be clear about this distinction.

This general line of argument – which takes account of different obligations that doctors have – might seem to explain well the situation that we find with young people. They can consent to treatment. This is because it would be a failure to respect their autonomy were we to treat them without their voluntary informed agreement, but not a failure to respect their autonomy were we to treat them with that agreement. As such, their voluntary informed agreement to medical treatment changes the normative status of the act of giving them the treatment from one which is wrong on the grounds that it fails to respect their autonomy to one that is not wrong on those grounds. But because the obligation to respect their autonomy is only a *prima facie* obligation it can be overridden in some cases. Where the treatment is required to provide some considerable benefit to a young person the doctor's obligation to do what is best for her patient can override the obligation to

respect her autonomy. In such situations it is not all things considered wrong to give medical treatment to a young person who has refused it. In this way it seems that the practice by which the courts have overridden refusals of treatment by competent young people on the grounds that this is in their best interests is what is in fact called for if they are to support the moral obligations health care professionals have towards patients.

If there is a problem here it is that everything I have said about respect for autonomy and what it requires would apply equally to the case where an adult is the patient. If this is right then there would be cases where the obligation to respect their autonomy is outweighed by other moral obligations (Dawson and Garrard, 2006). However, it might well be thought that there is an important difference between the obligations that we have to adults and those we have to young people (even where they are competent) that explains the difference in the way that we treat refusals. This is that the obligation to benefit someone, or to act in ways that prevent some harm befalling them, is stronger when that individual is not yet an adult than it is when she is an adult. We have, it might also be thought, obligations to protect those who are not adults from harm (including harm that they might impose on themselves) that we do not have (or at least do not have to the same extent) when it comes to adults. Conversely, it might also be thought that we have a stronger obligation to respect the autonomy of adults than of autonomous young people. This is because our interest in being recognised as someone who is capable of making our own decisions, and for whom it is important that we make our own decisions, develops over time and is thus stronger when we are adults than it is when we are 16 or 17. As such, it is worse, so this line of argument goes, to treat an adult as if they were incompetent (or more colloquially to treat them as a child) than it would be to treat a 16 year old in this way. If all this is right then when we come to balance the obligation to benefit the patient against the obligation to respect their autonomy (which we will need to do in all cases where a competent patient refuses treatment that is best for them) this is more likely to tip in favour of giving the treatment (and so doing what is best for the patient) over not doing so (and so doing what will respect their autonomy) when the patient is a young person than when the

patient is an adult. This will be the case even where the benefits of treatment are comparable in the two cases.

## Conclusion

The starting point of this paper was that there is an apparent anomaly in Irish law in that when it comes to consenting to medical treatment young people are treated in the same way as adults (their consent is needed and is morally significant) whereas when it comes to refusals of treatment they are treated in the same way as younger children (their refusal can legitimately be overridden in order to benefit them). The problem with this is that consent and refusal seem to be necessarily connected such that if one can consent then one can refuse, and if one cannot refuse then one cannot consent. The existing legal position therefore looks to be problematic, and has led to recommendations that the law be changed to make explicit that young people can both consent to and refuse medical treatment (Law Commission Report, 2011:92-93).

I have argued that appearances are deceptive here and that we should resist this move. It is important that we keep in mind two distinctions that are easy to overlook. The first is between cases in which young people can consent and those in which they are unable to refuse. The second is between things that are *prima facie* morally wrong and those things that are wrong all things considered. My argument has been that the young people we are concerned with in this paper are autonomous in the sense standardly used in medical ethics – they have an interest in making decisions for themselves, an interest that their doctor should respect. Because of this it would be *prima facie* morally wrong to give them medical treatment without their consent, just as would be the case if they were a competent adult. But doctors also have another obligation – to do what is best for the patient – that can come into conflict with the obligation to obtain consent before giving treatment. Where the obligation to benefit is the stronger, then this will outweigh the obligation to obtain consent (that is, the obligation to respect the patient's autonomy). In such cases it would not be all things considered wrong to give the patient the treatment even if she refuses it. That is, the widely held account in medical ethics, that doctors have a number of potentially conflicting *prima facie*

obligations, would support the current way in which young people's consent and refusal are treated.

The problem from the perspective of medical ethics is not with how young people are treated but with how adults are treated. In particular, it is unlikely that the position outlined here can support the idea that it is always morally wrong all things considered to give a competent adult medical treatment she refuses. It is important to note however that this does not in itself show that there is anything wrong with the law in Ireland as it stands. This will depend on the justification for the requirement that the patient's consent be obtained in all cases before treatment is given to a competent adult. For example, it may be justifiable to impose a blanket ban on giving treatment to competent adults where they have refused it if there is a risk that doctors might impose treatment on the basis that this is what is best for the patient – where this judgment reflects the doctor's own value system, and views about how other people should live – on patients with very different views about what is best for them. This is not the place to enter this debate. My aim has rather been to argue that the current situation in which young people can consent to treatment, but where it is sometimes treated as justifiable all things considered to give them treatment they refuse is both coherent and what would be supported by considerations of doctor's moral obligations to their patients.

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<sup>i</sup> This is not, of course, to deny that she can agree to being given the treatment. It may in practice be important to gain that agreement even in cases like this. It is much easier to give treatment to a co-operative patient than it is to give it to a patient who resists. But such agreement would not constitute consent – that is, it would not change the normative status of the act of providing the treatment.

<sup>ii</sup> In setting out this account I will be taking autonomy to be a feature of persons rather than a feature of choices – where an autonomous choice is an intentional choice made without controlling influences by a person who has understanding of relevant information – as occurs in some parts of the medical ethics literature (see, for example, Beauchamp and Childress, 2009:100-101). The reason for this is that such accounts struggle to explain why it would be wrong to give a competent patient treatment she

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has refused where that refusal does not count as autonomous – for example because the patient lacks understanding of what is proposed (see Walker, 2013).